

DHHS - Office of MaineCare Services
Rule, State Plan Amendment, and Waiver Status Report
October 2013

In APA Process*

Chapter II, Section 85, Physical Therapy Service

The Department is proposing changes to this rule to require Prior Authorization for all Physical Therapy Services for persons age 21 and older. The Department also proposes the following changes:

- a. Adding a definition for Terminal Illness,
- b. Adding new covered services and clarifying covered services and their limits,
- c. Limiting supplies to splinting and adding the link to the Department's Rate Setting website,
- d. Adding some language and clerical changes to clarify the policy.

Proposed: September 18, 2013

Public Hearing: October 28, 2013

Staff: Cari Bernier

Comment Deadline: November 7, 2013

Chapter II, Section 68, Occupational; Therapy Service

The Department is proposing changes to this rule to require Prior Authorization for all Occupational Therapy Services for persons age 21 and older. The Department also proposes the following changes:

- a. Adding a definition for Long-Term Chronic Pain and Terminal Illness,
- b. Adding new covered services and clarifies covered services and their limits,
- c. Limiting supplies to splinting only and adds the link to the Department's Rate Setting website,
- d. Adding some language and clerical changes to clarify the policy.

Proposed: October 1, 2013

Public Hearing: October 28, 2013

Staff: Cari Bernier

Comment Deadline: November 7, 2013

Chapter 101, MaineCare Benefits Manual, Chapter X, entitled Non-categorical Adults

The Department of Health and Human Services (DHHS) is proposing to repeal Chapter 101, MaineCare Benefits Manual, Chapter X, Section 2, Non-categorical Adults.

Proposed: October 1, 2013

Public Hearing: October 28, 2013

Staff: Cari Bernier

Comment Deadline: November 7, 2013

MaineCare Benefits Manual (MBM), Chapter 1, Section 1

The Department is proposing the following changes to this rule, for the following reasons:

- (1) removed references to Dirigo Choice, since the Maine Legislature has dissolved the Dirigo Health Agency (P.L. 2013, ch. 368, Sec. A-19);

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- (2) as required by 45 CFR 162.410, requires that any MaineCare provider that is a “covered health care provider” must obtain a National Provider Identifier (NPI);
- (3) requires that MaineCare Providers must include their NPI on their MaineCare Provider Agreements and MaineCare enrollment applications, and requires updates for new or changed NPIs;
- (4) requires that all MaineCare Providers must include their NPI on all MaineCare claims, pursuant to the Affordable Care Act, Section 6402(a) as codified in 42 CFR 431.107, or those claims will be denied;
- (5) pursuant to 42 CFR 455.410, specifies that in order for MaineCare to reimburse for services or medical supplies or prescriptions resulting from a provider’s order, prescription or referral, the ordering prescribing or referring (OPR) provider must be enrolled in MaineCare, and the OPR provider’s NPI must be on the claim;
- (6) Pursuant to P.L. 2013, c. 368, Part A-34, effective January 1, 2014, if approved by CMS, the Department will limit cost sharing payments, for the Qualified Medicare Beneficiary Without Other Medicaid (QMB Only) population, to hospital and nursing facility providers to the amount necessary to provide a total payment equal to the amount MaineCare would pay for these services under the State plan. The Department will seek CMS approval to amend its State plan for this change.
- (7) Finally, the Department made some additional changes to the 1.07-5 (Medicare provision), all to comport with the current State plan, and these changes also reflect the Department’s current practice: (a) Clarified that the cost sharing is limited in that it cannot exceed the lowest rate that Medicare determines to be the allowed amount; (b) deleted references to “Medicare Part B” in provisions where the provisions related both to Medicare A and B, pursuant to the State plan; (c) deleted a provision regarding claims received from January 1, 1997 to February 29, 2000, since that time period has long passed.

Proposed: October 1, 2013
Staff: Michael Dostie

Public Hearing: October 28, 2013
Comment Deadline: November 7, 2013

MaineCare Benefits Manual (MBM), Chapter VI, Section 2, MaineCare DirigoChoice Initiatives

This proposed rule repeals in its entirety MaineCare Benefits Manual, Chapter V, Section 2, MaineCare DirigoChoice Initiatives. The repeal of MaineCare Benefits Manual, Chapter V, Section 2, MaineCare DirigoChoice Initiatives is necessary to help supplement appropriations and allocations for the expenditures of State Government and to amend certain provisions of law necessary to the proper operations of State Government. Public Law, Chapter 368, under the Dirigo Health Fund eliminates positions and reduces funding to reflect the dissolution of the

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DirigoHealth Agency in fiscal year 2013-14. It also reduces funding to reflect that the Dirigo Health program is no longer required and transfers funding related to a new, separate and distinct fund for the Fund for a Healthy Maine from other special revenue funds.

Proposed: October 1, 2013
Staff: Michael Dostie

Public Hearing: October 28, 2013
Comment Deadline: November 7, 2013

Maine State Services Manual, Chapter 104, Section 4 Maine Part D Wrap Benefits

This rule is proposed to permanently adopt the provisions now in place by emergency rule that eliminate coverage of Medicare Part D copayments for members of the Medicare Savings Program who are not eligible for, or receiving, the full MaineCare benefit. This change is being made pursuant to PL 2013, Chapter 368, Part A, Section A-34, the Maine Biennial Budget.

Proposed: August 27, 2013
Staff: Ann O'Brien

Public Hearing: September 23, 2013
Comment Deadline: October 3, 2013

Chapter II, Section 45, Hospital Services

This proposed rulemaking seeks to implement rules emergency rules that became effective August 27, 2013, which implement provisions in the 2014-15 budget law (P.L. 2013, ch. 368 LD 1509). Specifically, this rulemaking will increase reimbursement for therapeutic leave during days awaiting nursing facility placement from one per year to twenty per year.

Estimated Fiscal Impact: The combined General Fund impact of this policy change and the policy change to Chapter II, Section 67, and Nursing Facility Services (which was part of the same budget initiative) is an increase of \$21,702 in SFY 2013, and savings of \$112,760 and \$113,513 in SFYs 2014 and 2015, respectively.

Proposed: August 27, 2013
Staff: Peter Kraut

Public Hearing: September 23, 2013
Comment Deadline: October 3, 2013

Chapter II, Section 67, Nursing Facility Services

This emergency rulemaking seeks to implement rules emergency rules that became effective August 27, 2013, which implement provisions in the 2014-15 budget law (P.L. 2013, ch. 368 LD 1509). Specifically, this rulemaking will increase reimbursement for: (1) therapeutic leave from one per year to twenty per year, and (2) bed holds from four days per year to seven days per inpatient hospitalization.

Estimated Fiscal Impact: The combined General Fund impact of this policy change and the policy change to Chapter II, Section 45, and Hospital Services (which was part of the same budget initiative) is an increase of \$21,702 in SFY 2013, and savings of \$112,760 and \$113,513 in SFYs 2014 and 2015, respectively.

Proposed: August 27, 2013

Public Hearing: September 23, 2013

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Staff: Peter Kraut

Comment Deadline: October 3, 2013

Chapter II, Section 97 Private Non-Medical Institution Services

This proposed rule seeks to permanently adopt the changes made by an emergency rule, effective on June 26, 2013, which eliminates Private Non-Medical Institution Services (PNMI), Appendix D (Child Care Facilities), Model 3 (Intensive Mental Health Services for Infants and/or Toddlers). In a separate rulemaking, the Department is seeking to provisionally adopt a major substantive rule for Chapter III, Section 97, which eliminates the reimbursement rate for this service. Although eligible infants and toddlers no longer have access to PNMI Appendix D, Model 3 Intensive Mental Health Services, they remain eligible for medically necessary Behavioral Health Services through Chapter II, Section 65, Behavioral Health Services.

Proposed: July 30, 2013

Public Hearing: August 26, 2013

Staff: Ann O'Brien

Comment Deadline: September 5, 2013

Chapter III, Section 97 Private Non-Medical Institution Services

This proposed major substantive rule eliminates the reimbursement rate for Private Non-Medical Institution Services (PNMI), Appendix D (Child Care Facilities), Model 3 (Intensive Mental Health Services for Infants and/or Toddlers). The Department seeks to provisionally adopt the changes made by an emergency major substantive rule, effective on June 26, 2013. The Department seeks to eliminate intensive Mental Health Services for infants and/or toddlers through a separate rulemaking for Chapter II, Section 97. Although eligible infants and toddlers will no longer have access to PNMI Appendix D, Model 3 Intensive Mental Health services, they remain eligible for medically necessary Behavioral Health Services through Section 65, Behavioral Health Services, which services shall be reimbursed at the rates set forth in Chapter III, Section 65.

Proposed: July 30, 2013

Public Hearing: August 26, 2013

Staff: Ann O'Brien

Comment Deadline: September 5, 2013

Chapter III, Section 45, Hospital Services

This proposed rulemaking seeks to permanently adopt the emergency rulemaking that implemented provisions in the 2014-15 budget law (P.L. 2013, ch. 368 LD 1509) by:

- increasing the reimbursement rate per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area to \$9,128.31; and
- reducing the outpatient Ambulatory Payment Classification (APC) rate for Acute Care Non-Critical Hospitals and Rehabilitation Hospitals from 93% to 83.7% of the adjusted Medicare APC rate for outpatient services; if multiple procedures are performed, the Department will pay 83.7% -- rather than 93% -- of Medicare's single bundled APC rate; calculations for outlier payments will follow Medicare rules and also be paid at 83.7% -- rather than 93% -- of the Medicare payment.

The rulemaking also corrects two clerical errors: (1) page 15, the proper heading should be "Section 45.04 Acute Care Critical Access Hospitals"; and (2) on pages 11 and 18, removes "un"

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from “unadjusted” so the proper word is “adjusted.” The Department is seeking approval from the Centers for Medicare and Medicaid Services for a state plan amendment for this change. The Department estimates that the cost of increasing the reimbursement rate per psychiatric discharge is \$259,911 in each state fiscal year 2014 and 2015. The savings from reducing outpatient APC rates is \$6,055,500 in each state fiscal year 2014 and 2015. The aggregate impact of these two changes is a savings of \$5,795,589 in each state fiscal year 2014 and 2015. All of the funds for this methodology change have been approved by the Legislature and signed into law.

Proposed: July 23, 2013
Staff: Peter Kraut

Public Hearing: August 19, 2013
Comment Deadline: August 29, 2013

Maine State Services Manual, Chapter 104, Section 4 Maine Part D Wrap Benefits – *Will not be finally adopted until after New Emergency rule is finally adopted*

This rule will amend the description of prescription drug rate changes for Maine Part D Wrap Benefits and eliminate the need to annualize changes through rulemaking. The Department pays 100% of the member's co-payment for generic drugs, and 50% of the member's co-payment for brand name drugs up to \$10.00. Effective January 1, 2013, the co-payment for generic drugs will increase from \$2.50 to \$2.65, and the cost of brand name drugs will increase from \$6.50 to \$6.60, which means the State share is changing from \$3.25 to \$3.30. The new co-payments will increase State expenditures by \$0.15 for generic drugs and \$0.05 for brand name drugs for an additional cost of \$130,532 for six months of SFY13 and six months of SFY14. The members participating in Maine Part D Wrap benefits will experience an increase or decrease annually depending on the parameters set by CMS.

Proposed: April 30, 2013
Staff: Ann O'Brien

Public Hearing: May 29, 2013
Comment Deadline: June 8, 2013

Chapter II, Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders

The Department is proposing changes to the rule to comply with the concurrent operation of a 1915 (b) Non-Emergency Transportation Waiver. These proposed changes to Section 32 will be effective only upon implementation of the 1915(b) Non-Emergency Transportation Waiver. The proposed changes to Section 32 include referencing the regional, risk-based, Pre-Paid Ambulatory Health Plan (PAHP) Brokerages operating under a 1915(b) waiver approved by the Centers for Medicare and Medicaid Services (CMS). Under risk-based contractual agreements, the Department will contract with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of Non-Emergency Transportation (NET) services for eligible MaineCare members. The Broker(s) will be responsible for establishing a network of NET drivers to deliver NET transportation services to eligible members who live in their assigned region.

The Department is also proposing a number of other changes:

1. The Department is proposing changes to the definitions of “seclusion” and “restraint” to conform to the definitions employed in the Department of Education’s regulations (5-71 C.M.R. ch. 33). The Department of Health and Human Services was directed by the Legislature’s Committee on Health and

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Human Services to amend Chapter II to mirror the definitions of seclusion and restraint in the Department of Education's regulations.

2. The Department is proposing to replace the term "aggression" throughout the rule with "self-injurious behavior and/or aggression."
3. The Department is proposing to add language clarifying that, for purposes of initial and continuing eligibility, the annual cost of a member's services under Section 32 may not exceed the statewide average annual cost of care for an individual in either (a) an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or (b) an Inpatient Psychiatric facility for individuals age 21 and under, depending upon the level of care at which the individual qualified for the waiver. This is not a new limit; the Department is proposing the changes to clarify that these limits are not fixed numbers, but instead change each year based upon the prior year's statewide average annual cost of care for the respective facility type.
4. The Department is proposing to add a number of definitions (including Authorized Agent, Intellectual Disability, and Pervasive Developmental Disorders), and to change the term "Mentally Retarded" to "Intellectual Disability," as required by P.L. 2012, ch. 542, § B(5), An Act To Implement the Recommendations of the Department of Health and Human Services and the Maine Developmental Disabilities Council Regarding Respectful Language.
5. The Department is proposing clarification of, and additions to, the requirements for providers of Section 32 services. These include, among others, clarification of the circumstances under which Behavioral Health Professionals may assist with administration of medication, requirements for

Respite Service providers, and a requirement that providers put in place a Department-approved informed consent policy.

Proposed: August 3, 2013
Staff: Ginger Roberts-Scott

Public Hearing: August 26, 2013
Comment Deadline: September 5, 2013

10-144 Chapter 115, Principles of Reimbursement for Residential Care Facilities-Room and Board Costs, Sections 20-21(e) and 20.5. This proposed rule will implement Resolve 2011, ch. 106, LD 790, which was signed into law by the Governor on July 8, 2011. The proposed rule makes these changes to the current rule: 1.) Effective October 25, 2013, for an energy efficient improvement to be reimbursable, in addition to any other standards required in Chapter 115, the energy efficient improvement must be recommended as a cost-effective energy efficient improvement in an energy audit conducted by an independent energy audit firm, as evidenced in a written document, or must be determined to be cost-effective by the Efficiency Maine Trust; 2.) Effective July 8, 2011, for all proposed new construction, acquisitions or renovations involving capital expenditures, in the aggregate, that exceed Three Hundred and

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Fifty Thousand Dollars (\$350,000) or more in one fiscal year, providers must submit plans, financial proposals, and projected operating costs to the Department for approval in order for costs to be reimbursed (Section 20.5); and 3.) Effective July 8, 2011, capital expenditures for energy efficiency improvements, replacement equipment, information systems, communication systems and parking lots and garages must be excluded from the cost of the project in determining whether it is subject to prior written approval for energy efficiency improvements. This proposed rule will benefit providers to the extent they will not need to seek prior Department approval for capital projects that are under \$350,000. However, all such costs will continue to be reviewed and audited for allowability of the costs, in compliance with the Chapter 115 regulations. The proposed rulemaking documents are under review and approval by the Commissioner's office. Public hearing is scheduled for September 9, 2013. The comment deadline is September 19, 2013.

Staff: Michael Dostie

Effective Date: October 25, 2013

Rules Adopted or Provisionally-Adopted Since Last Status Update

Chapter III, Section 65, Behavioral Health Services

This rule has adopted the emergency rule that restores the reimbursement rates for Licensed Clinical Professional Counselors (LCPCs) and Licensed Marriage and Family Therapists (LMFTs) to levels in place prior to March 1, 2013 for MaineCare Benefits Manual, Chapter III, Section 65, Behavioral Health Services beginning July 1, 2013. The Legislature mandated this rule in P.L. 2013, Ch. 368 § WWW-1 and authorized the Department to do emergency rulemaking. This change in rates requires a State Plan Amendment to be approved by the Centers for Medicare and Medicaid Services (CMS). The Department will request approval of a State Plan Amendment.

Adopted: September 28, 2013
Staff: Ann O'Brien

Public Hearing: August 12, 2013
Comment Deadline: August 22, 2013

Chapter II, Section 65, Behavioral Health Services

This rule is adopted in accordance with P.L. 2011, ch. 657, (L.D. 1746), Part A, S § S-1 (125th Legis.) and will limit MaineCare reimbursement for methadone treatment of addiction to opioids to a maximum of twenty-four (24) months per lifetime, except as permitted with prior authorization beyond twenty-four (24) months. Only treatment after January 1, 2013 will count toward the limit.

Effective: August 31, 2013

Staff: Ann O'Brien

Chapter II, Section 45, Hospital Services

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Staff: Peter Kraut

Chapter II, Section 67, Nursing Facility Services

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Staff: Peter Kraut

Chapter III, Section 45, Hospital Services

This emergency rulemaking, effective July 1, 2013, implements provisions in the 2014-15 budget law (P.L. 2013, ch. 368 LD 1509). Specifically, this rulemaking:

- increases the reimbursement rate per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area to \$9,128.31; and
- reduces the outpatient Ambulatory Payment Classification (APC) rate for Acute Care Non-Critical Hospitals and Rehabilitation Hospitals from 93% to 83.7% of the adjusted Medicare APC rate for outpatient services; if multiple procedures are performed, the Department will pay 83.7% -- rather than 93% -- of Medicare's single bundled APC rate; calculations for outlier payments will follow Medicare rules and also be paid at 83.7% -- rather than 93% -- of the Medicare payment.

The rulemaking also corrects two clerical errors: (1) page 15, the proper heading should be "Section 45.04 Acute Care Critical Access Hospitals"; and (2) on pages 11 and 18, removes "un" from "unadjusted" so the proper word is "adjusted." The Department is seeking approval from the Centers for Medicare and Medicaid Services for a state plan amendment for this change. The Department estimates that the cost of increasing the reimbursement rate per psychiatric discharge is \$259,911 in each state fiscal year 2014 and 2015. The savings from reducing outpatient APC rates is \$6,055,500 in each state fiscal year 2014 and 2015. The aggregate impact of these two changes is a savings of \$5,795,589 in each state fiscal year 2014 and 2015. All of the funds for this methodology change have been approved by the Legislature and signed into law.

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In Draft (And Governor's Office Approval Received)

10-144 Chapter 115, Principles of Reimbursement for Residential Care Facilities-Room and Board Costs, Sections 20-21(e) and 20.5 - This proposed rule will implement Resolve 2011, ch. 106, LD 790, which was signed into law by the Governor on July 8, 2011. The proposed rule makes three changes to the current rule: 1.) Effective September 2013, for an energy efficient improvement to be reimbursable, in addition to any other standards required in Chapter 115, the energy efficient improvement must be recommended as a cost-effective energy efficient improvement in an energy audit conducted by an independent energy audit firm, as evidenced in a written document, or must be determined to be cost-effective by the Efficiency Maine Trust; 2.) Effective July 8, 2011, for all proposed new construction, acquisitions or renovations involving capital expenditures, in the aggregate, that exceed Three Hundred and Fifty Thousand Dollars (\$350,000) or more in one fiscal year, providers must submit plans, financial proposals, and projected operating costs to the Department for approval in order for costs to be reimbursed (Section 20.5); and 3.) Effective July 8, 2011, capital expenditures for energy efficiency improvements, replacement equipment, information systems, communication systems and parking lots and garages must be excluded from the cost of the project in determining whether it is subject to prior written approval for energy efficiency improvements. This proposed rule will benefit providers to the extent they will not need to seek prior Department approval for capital projects that are under \$350,000. However, all such costs will continue to be reviewed and audited for allowability of the costs, in compliance with the Chapter 115 regulations.

Staff: Michael Dostie

Effective Date: October 25, 2013

In Draft (And Governor's Office Approval not yet requested)

Chapter II, Section 90, Physician Services

The Department is proposing numerous changes to this rule. The proposed rule will implement a CMS requirement that anesthesiology services be billed in one (1) minute rather than fifteen (15) units of value and that anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) be supervised by the operating doctor of medicine or osteopathy in accordance with 42 C.F.R. § 482.52 (a)(4).

Also, the proposed rule will delete Section 90A-04 regarding prior authorization for transplants, establish new criteria for reimbursement and require the nationally accredited United Network for Organ Sharing (UNOS) to recommend that a transplant be performed. The rule will allow In-State kidney and corneal transplants to be performed without prior authorization. When medically necessary, bone marrow or stem cell transplants are covered.

Moreover, the following changes have been proposed:

- Definitions for the terms "Face-to-Face Encounter" for Durable Medical Equipment (DME) and Home Health Services were added,
- Provider qualifications for obstetrical services have been amended
- Orthognathic surgery will only be approved where there is a medical necessity.

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- Certified Nurse Midwives, Dentists (General, Orthodonture, Pedodontist) and Dental Hygienists practicing within the scope of their certification and licensures can be employed in a physician's practice,
- Surgical services for post-operative treatment will be amended to comply with the CMS standard fee schedule for durational global surgical periods (0-10-90 days).
- Bariatric procedures must be performed at a nationally certified center recognized by the American College of Surgeons or the Surgical Review Corporation.
- In general, BRCA1 and BRCA2 testing are covered.
- Restricted services for circumcision will be covered if medically necessary and not cosmetic, except when deformities are the result of cancer, disease, trauma or birth defects.
- Disclosure requirements in Section 90.08-1 will be amended to ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Rule.
- Protection of privacy when using Qualified Electronic Health Records (EHR).

Also within Sec 90 is the ACA's Primary Care Physicians Payment Rate Increase. This mandatory ACA initiative will increase the current Medicaid Rate for certain primary care physicians to 100% of the Medicare fee schedule in calendar years 2013 and 2014. This will apply to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. This initiative will also apply to all subspecialties related to those three specialty categories to the extent that they provide E&M services.

Eligible services provided by advance practice clinicians providing services within their scope of practice and under the supervision of an eligible physician will be eligible for higher payment; this includes those not specifically mentioned in the proposed rule such as nurse midwives; independently practicing advance practice clinicians (i.e., those **not** under the supervision of an eligible physician) are **not** eligible for increased payment.

Physicians will be required to self-attest that they are either board certified in family medicine, general internal medicine or pediatric medicine or a subspecialty within those specialties or that 60% of all Medicaid services they bill for are specified E&M or vaccine administration codes. Physicians recognized by the American board of physician specialties, the American osteopathic association and the American board of medical specialties are included. In order to receive the higher payment, qualifying physicians and advance practice clinicians must be providing services under the following pay-to/service location provider types: 35-Hospital/062-Hospital Based Professionals; 51-Physicians; and 54-Physician Group.

Estimated Fiscal Impact:

The Department expects that this rulemaking will cost the Department approximately \$150,000 in SFY 2013. This Fiscal impact is the high end of the expected cost of BRCA testing. BRCA1 and BRCA2 are human gene mutations that have been linked to hereditary breast and ovarian cancer. Based on cost estimates, BRCA testing ranges from \$300 to \$3,000, depending on whether a patient has a limited test or a full test. The cost will not go higher than \$150,000, but will be much lower. Not all data required for a full analysis is available, as family history is a

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big factor in the determination of the need of the BRCA test. With no history in the system of this new testing, the Department is limited in the amount of data it can analyze.

This proposed rulemaking will have no other impact on the regulated community.

Staffs: Michael J. Dostie and Peter Kraut

Chapter 1, Section 3, Ordering and Referring Providers

The proposed draft rule will implement the Patient Protection Affordable Care Act (PPACA) which specifies that Medicaid cannot pay eligible rendering providers for any health care service requiring a referral, order, or prescription from a physician or other health care professional unless the ordering, referring or prescribing provider is enrolled in MaineCare. Furthermore, the proposed rule requires all providers of medical or other items or services that qualify for a National Provider Identifier (NPI) to include their NPI on all Medicare and Medicaid enrollment applications and on all claims for payment submitted under the Medicare and Medicaid programs. If a claim fails to include the NPI, or the legal name of the physician or health care professional that ordered or prescribed the service, or referred the client for service, Medicaid reimbursement will be denied.

Staff: Michael J. Dostie

Effective Date: December 23, 2013

Chapter X, Section 1, Benefit for People Living with HIV/AIDS Renewal

Maine is requesting to renew the Maine HIV/AIDS Section 1115 Demonstration Waiver under the Social Security Act effective January 1, 2014. The objective of this waiver is to provide more effective and earlier treatment, improve access to continuous health care, provide a comprehensive package of services to people living with HIV/AIDS, to assist in enhancing compliance with treatment and medication regimens, and to meet cost-effectiveness as required by federal regulations. The key feature of this waiver which allows for the objectives to be successfully accomplished is the care management services. Maine is not anticipating any impact on enrollment or spending unless a Medicaid expansion occurs. If so, some enrollees would move from the waiver to full MaineCare benefits. Maine does not anticipate asking for any substantial modifications to the existing Section 1115 Demonstration waiver. Maine does not anticipate asking for any substantial modifications to the existing Section 1115

Demonstration waiver. Maine has continued to make improvements with care management and cost saving initiatives. Member satisfaction rates with the program have continued to increase. Two public hearings have been held and favorable comments have been received.

A third public hearing was held on April 3, 2013 for public comment and input to coincide with the submission of the application. No comments were received. The HIV Sec. 1115 Demonstration renewal narrative is in final draft and will be vetted internally before it will be submitted to CMS.

Staff: Michael Dostie

Effective: January 1, 2014

Chapters II and III, Section 25, Dental Services

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This rule is being proposed in order to update the principles of reimbursement (Chapter III) to include 2012 /2013 CDT codes. This rule change will also add Independent Practice Dental Hygienists, Dental Externs, and Dental Residents as qualified providers.

Staff: Peter Kraut

Chapter II Section 31, Federally Qualified Health Center Services

This rule is being proposed in order to add Independent Practice Dental Hygienists, Dental Externs, and Dental Residents as qualified providers.

Staff: Peter Kraut

Maine State Services Manual, Chapter 104, Section 6, Independent Practice Dental Hygienist Service for MaineCare Members

This new rule will provide that the Department will reimburse Independent Practice Dental Hygienist (IPDHs) for providing certain services to MaineCare members from 10/1//12 through the effective date of a forthcoming State Plan Amendment to add IPDHs under Maine's State Plan. The services are: prophylaxis performed on a person who is 21 years of age or younger; topical application of fluoride performed on a person who is 21 years of age or younger; provision of oral hygiene instructions; the application of sealants; temporary fillings; and x-rays (under a temporary geographically limited pilot program overseen by the Maine Board of Dental Examiners).

Staff: Peter Kraut

Chapter II, Section 80, Pharmacy Services

This emergency rule will adopt technical corrections to statutory language originally adopted pursuant to P.L. 2011, Chap. 657, Part O, § 2, the DHHS 3rd Supplemental Budget. These technical corrections are made pursuant to P.L. 2013, Chap. 368, Part AAAAA (L.D. 1509, "An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2013, June 30, 2014 and June 30, 2015").

This emergency rule makes several changes to the rule that was originally adopted, including:

- Changing the term "alternative intervention treatments" to "therapeutic treatment options."
- Adding language explaining that the Department will reimburse for an initial fifteen (15) day prescription for the treatment of a new onset of acute pain.
- Reducing the number of days that the Department will reimburse for opioid medications for the treatment of a new onset of acute pain from forty-five (45) days per year to forty-two (42) days per year.

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The Department is also adding clarifying language indicating that the limits established for acute pain following a surgical procedure are for the treatment of post-operative care. This rule also revises language regarding second opinions, stating that second opinions are required for the Department to reimburse for opioid drugs for a diagnosis typically known to have a poor response to opioid drug treatment. The previous language that is being changed stated that second opinions are required when opioids are prescribed to a MaineCare member who has been typically known to have a poor response to opioid drugs.

Other changes include adding language allowing exceptions to be established through the MaineCare Preferred Drugs List (PDL), and including members residing in a nursing facility on the list of exceptions.

Estimated Fiscal Impact: The original changes made pursuant to P.L. 2011, Chap. 657, Part O, § 2, the DHHS 3rd Supplemental Budget, were projected to save the Department approximately \$1,000,000 in SFY 12-13. The Department anticipates that the enactment of the technical corrections made through this emergency rule, pursuant to P.L. 2013, Chap. 368, Part AAAAA, (L.D. 1509, “An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2013, June 30, 2014 and June 30, 2015”), will be cost neutral.

Staff: Amy Dix

State Plan Amendment Status:

09-016 Transportation, Bus Passes - This SPA adds bus passes as a covered service when transportation providers find this the most cost effective method to provide transportation to medically necessary services.

Status: Submitted 9/30/09 “Off Clock”, as CMS is reviewing a related 1915B waiver.

10-013 Coverage of PNMI Services - This SPA adds more detail, at request of CMS, of what is covered and who are qualified providers in PNMI facilities. No changes in coverage or benefit.

Status: Submitted September 24, 2010. RAI Issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April, and a conference call was held in May, 2011 to start working through CMS questions. Responses withdrawn 5/6, currently Off Clock, IMD analysis required.

10-014 Coverage of Behavioral Health Services - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for behavioral health services. No changes in coverage or benefit are made.

Status: Submitted September 24, 2010. RAI issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April. Withdrew responses 5/6. Currently off clock, IMD analysis required.

10-015 Coverage of Rehabilitative Services - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for rehabilitative services. No changes in coverage or benefit are made.

Status: Submitted September 24, 2010. RAI Issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April. Responses Withdrawn 5/6, currently Off Clock, IMD analysis required.

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10-016 Coverage of Personal Care Services - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for personal care services. No changes in coverage or benefit are made.

Status: Submitted September 24, 2010. RAI Issued December 2010, Responses submitted to CMS March 17, 2011. Additional questions received last week of April. Responses withdrawn 5/6. Currently off clock, IMD analysis required.

12-006 Increase of limits for Chiropractic and Vision Services - The state is requesting approval to increase the limits for Chiropractic and Vision services, pursuant to the 1st Supplemental Budget, P.L. 2011, CH. 477.

Status: Submitted June 29, 2012.
Informal RAI questions received on August 8, 2012.
Informal RAI responses submitted to CMS on September 10, 2012.
Formal RAI received September 20, 2012.
Formal RAI responses submitted December 22, 2012
Follow Up questions received September 24, 2013

12-007 Pharmacy Coverage and Reimbursement - The state is requesting approval to revise and add several reimbursement methodologies for Pharmacy services. The reduction of reimbursement for brand-name drugs to AWP minus (-) 16%, the request to impose a mandatory generic substitution and eliminate coverage of smoking cessation products for all members except for pregnant women is made pursuant to the 1st and 3rd Supplemental Budgets.

Status: Submitted June 29, 2012.
Informal RAI questions received on August 13, 2012.
Informal RAI responses submitted to CMS on September 10, 2012.
Formal RAI received September 26, 2012.
Formal RAI extension received December 31, 2012
Formal RAI submitted August 19, 2013
Follow-Up Questions received September 21, 2013
Follow-Up Questions submitted September 30, 2013

12-008 Reimbursement for Services other than Inpatient Hospital - The state is requesting approval to decrease the rates of reimbursement for Podiatry, Occupational Therapy, Physical Therapy and Opioid Treatment pursuant to the 1st Supplemental Budget, P.L. 2011, CH. 477.

Status: Submitted June 29, 2012
Informal RAI questions received on August 8, 2012.
Informal RAI responses submitted to CMS on September 10, 2012.
Formal RAI received September 20, 2012.
Formal RAI responses submitted December 22, 2012
Follow Up questions received September 24, 2013

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12-015 Mandatory Pharmacy Co-Pays – this State Plan Amendment (SPA) is made to assure that Maine’s State Plan is updated to be consistent with policy changes that will need to be made to implement LD 346-An Act Regarding Pharmacy Reimbursement in MaineCare, which will implement mandatory co-payments for certain MaineCare members. In accordance with 42 CFR 447.76, the Department published notices in five (5) local papers, on the Departments website and held a public hearing regarding the proposed SPA. The Department did not receive any comments regarding the proposed SPA and there were no attendees at the public hearing.

Status: Submitted: 12/7/12
Informal RAI received 1/2/13
Informal responses submitted to CMS 1/15/13
Formal responses submitted to CMS 6/3/13
Budget neutral

12-017 PCP Increase -Medically Underserved Areas The Department received a request to increase the rate paid to physician-owned primary care medical practices that are located in Governor’s Designated Medically Underserved Areas. The requester provided information that, over the years, MaineCare reimbursement to other types of providers has steadily increased while reimbursement rates for physician-owned medical practices have steadily fallen behind. Section 1202 of the Affordable Care Act requires Medicaid programs to increase rates for Primary Care Physicians to 100% of the Medicare fee schedule, effective January 1, 2013. This rate increase will provide the additional financial support needed to assure that members have a free choice of providers and are able to access all medically necessary Primary Care services within their geographic area.

Status: Submitted 12/31/12
Informal RAI received 2/5/13
Informal responses submitted to CMS 2/22/13
Formal RAI received 3/28/13
Fiscal Impact: If the State Plan Amendment is approved, the proposed rate increase will cost \$440,058 for 3 months, in State and Federal funds. If the State Plan Amendment is not approved, the proposed rate increase will be \$440,058 for 3 months, in State general funds.

13-004 Substance Abuse Service – The State will be requesting approval to impose MaineCare reimbursement for methadone for the treatment of addiction to opioids to a lifetime maximum of twenty four (24) months, except as permitted with prior authorization beyond twenty-four (24) months.

Status Submitted 3/29/13
Informal RAI received 05/14/13
Informal responses submitted 6/24/13
Formal RAI received 6/26/13
Formal responses submitted 09/27/2013

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13-005 Physical Therapy services – The State will be requesting approval to increase the limits for Physical Therapy Services to allow for up to five (5) treatment visits and one (1) evaluation within twelve (12) months, when provided pursuant to a pain management care plan.

Status Submitted 3/29/13
 Informal RAI received 5/22/13
 Informal responses submitted 6/25/13
 Formal RAI received 6/27/13
 Formal responses submitted 09/27/2013

13-006 Pharmacy Services/ Pain Management – The State will be requesting approval for limits on opioid medication used for the treatment of pain

Status Submitted 3/29/13
 Formal RAI received 6/20/13

13-008 Behavioral Health -- The Maine State Legislature in P.L. 2013, Ch. 1, § A-23 (“An Act To Make Supplemental Appropriations and Allocations for the Expenditures of State Government and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2013”) directed the Department to reduce reimbursement rates by 5% for LCPC and LMFT. This change in rates requires a State Plan Amendment to be approved by the Centers for Medicare and Medicaid Services (CMS); the Department will request approval of a State Plan Amendment retroactive to March 5, 2013.

Status: Submitted 3/29/13
 Informal RAI received 5/13/13
 Formal RAI received 6/28/13
 Formal responses submitted 09/27/2013

13-013 Excluded Drugs, Barbiturates, and Benzodiazepine - The proposed Pharmacy Services amendment is being submitted to comply with Section 175 of the Medicare Improvement for Patient and Providers Act of 2008 which amended section 1860D-2(e)(2)(A) of the act to include Medicare Part D drug coverage of barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines for all medically accepted indications.

The State of Maine asks that this SPA be retroactive to the effective date of April 1, 2013. The Department of Health and Human (The Department) has made edits to its system to implement this change effective January 1, 2013. However, the submission of this SPA has been delayed in order to meet notice requirements.

Submitted 5/10/13
Formal RAI received 8/7/13

13-015 Inpatient Leave Days -- Payment of bed holds for a semi-private room for a short-term hospitalization of the member is proposed to change to seven (7) days (midnights) absence each fiscal year, as long as the member is expected to return to the nursing facility. Payment for these bed holds would be granted up to seven (7) days (midnights) absence during each twelve (12) month period. The Department will also, if CMS approves, increase reimbursement for a leave of

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absence from one (1) day in a twelve-month period to no more than twenty (20) day in leave of absence each fiscal year, and twenty (20) day of leave of absence during the twelve (12) month period each fiscal year.

Status: Submitted 6/28/13

13-002 Personal Care - The Department will be submitting this SPA to CMS. This SPA will request approval to consolidate all personal care services including consumer directed personal care services into one part of the Medicaid State Plan. This SPA will also establish standard levels of medical eligibility and acuity for all personal care services and propose a minimum standard staffing qualification across all personal care services. Finally it will establish a standard rate for home based personal care services provided by independent providers and agency providers and Maintains a per diem case mix adjusted rate for personal care services delivered in residential care settings.

Submitted 6/25/13

Recovery Audit Contractor Medical Director -The Department of Health and Human Services is seeking an exception to the requirement that a RAC have a full time Medical Director on staff. The Department requests that CMS allow a half-time (1/2) Medical Director rather than a full-time Medical Director under the Recovery Audit Contractor (RAC) Program. The basis for this request is that Maine is a small state and the need for a full-time equivalent RAC Medical Director should be reduced accordingly.

Submitted 6/28/13

Approved 9/23/13

Hospital Services Outpatient – The Department will be requesting approval to reduce the outpatient Ambulatory Payment Classification (APC) rate for Acute Care Non-Critical Hospitals and Rehabilitation Hospitals from 93% to 83.7% of the adjusted Medicare APC rate for outpatient services; if multiple procedures are performed, the Department will pay 83.7% -- rather than 93% -- of Medicare's single bundled APC rate; calculations for outlier payments will follow Medicare rules and also be paid at 83.7% -- rather than 93% -- of the Medicare payment.

Submitted 9/27/13

Hospital Services Inpatient - The Department will be requesting approval to increase the reimbursement rate per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area to \$9,128.31.

Submitted 9/27/13

Behavioral Health Maine's Legislature directed the Department to reduce restore rates by 5% for LCPC and LMFT. This change in rates requires a State Plan Amendment to be approved by the Centers for Medicare and Medicaid Services (CMS); the Department will request approval of a State Plan Amendment retroactive to July 1, 2013.

Submitted 9/27/13

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In Draft

Pharmacy Services - The proposed Pharmacy Services amendment is being submitted to comply with Section 175 of the Medicare Improvement for Patient and Providers Act of 2008 which amended section 1860D-2(e)(2)(A) of the act to included Medicare Part D drug coverage of barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines for all medically accepted indications

Waivers

RENEWAL-Section 19, Home and Community-Based Benefits for the Elderly and for Adults with Disabilities (CMS control #0276) - This waiver will be renewed for 7/1/13, the only anticipated changes are updating the performance measures in the quality sections of the waiver application.

Staff: Ginger Roberts-Scott

Status: Submitted to CMS 3/29/2013,
RAI received 4/26/13.
RAI submitted to CMS 5/31/13.
Renewed effective 7/1/13.

Waiver Amendments

Section 21, Home and Community-Based Benefits for Adults with Intellectual Disabilities or Autistic Disorder (CMS control # 0159) -

The state of Maine would like amend the waiver to clarify Shared Living and Family Centered Support as separate services from Home Support (Residential Habilitation). The state would like to add a new service called Home Support-Remote Support as part of Residential Habilitation. The state would like to separate Work Support (supported employment) into two services, individual and group. The state would also like to add two new services, Career Planning and Assistive Technology. For Communication Aids, ATP/OT/Audiologists will be added as qualified providers.

The state would like to put limits on Consultation Services. The state would like to add a reserved capacity category for Children transitioning to adult services. The state would also like to put a point in time limit in the waiver application. Appendix I-7 is also being revised to reflect that the participant has a cost of care. Appendix A.3 use of contracted entities, the state would like to add the use of contracted entities to this section.

Staff: Ginger Roberts-Scott

Status: in draft

Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders (CMS control # 0864) - This amendment will update the start date of the waiver.

Staff: Ginger Roberts-Scott

Status: in draft

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Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder (CMS control # 0467) -

The state of Maine would like to amend this waiver to add three new services. The state would like to add Home Support- 1/4 hour and Remote Support as part of Residential Habilitation. The state would also like to add Assistive Technology and Career Planning.

The state would like to separate Work Support (Supported Employment) into two services, Individual and Group Work Support. The state would also like to put a point in time limit in the waiver application. Appendix I-7 is also being revised to reflect that the participant has a cost of care. Appendix A.3 use of contracted entities, the state would like to add the use of contracted entities to this section.

Staff: Ginger Roberts-Scott

Status: in draft

Section 19, Home and Community-Based Benefits for the Elderly and for Adults with Disabilities (CMS control #0276) - This amendment will merge Sections 19 and 22 together.

Staff: Ginger Roberts-Scott

Status: in draft-Spring 2014

Section 18 Home and Community Based Services for Members with Brain Injury.

New Brain Injury Waiver-1915 (c)

Staff: Ginger Roberts-Scott

Status: in draft July 2014

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*PLEASE NOTE THAT ALL RULES ARE PROMULGATED IN COMPLIANCE WITH EXECUTIVE ORDER OF AUGUST 24, 2011 “AN ORDER TO IMPROVE REVIEW OF THE RULEMAKING PROCESS,” detailed at:

http://www.maine.gov/tools/whatsnew/index.php?topic=Gov_Executive_Orders&id=182022&v=article2011.

Please note: Public Hearings are no longer being held at 442 Civic Center Drive, Augusta. Please check the published rulemaking documents to find the location where the public hearing will be held for each individual rule.